Supreme Court, U.S.
FILED
JAN 30 1986
JOSEPH F. SPANIOL, JR.
CLERK

No. 85-632

IN THE

Supreme Court of the United States

October Term, 1985

CHARLES ATKINS, Commissioner of the Massachusetts Department of Welfare,

Petitioner,

v.

SANTOS RIVERA, Madeline McKenna, and all others similarly situated,

Respondents.

ON A WRIT OF CERTIORARI TO THE SUPREME JUDICIAL COURT FOR THE COMMONWEALTH OF MASSACHUSETTS

Brief of the Attorney General of the State of New York *Amicus Curiae*

ROBERT ABRAMS
Attorney General of the State of New York
The Capitol
Albany, NY 12224
(518) 473-6053

ROBERT HERMANN
Solicitor General
State of New York

PETER H. SCHIFF
Deputy Solicitor General
State of New York

ALAN W. RUBENSTEIN
Assistant Attorney General
State of New York

JOHN P. BAILLY, JR.
Deputy Counsel
New York State Department of Social Services

Of Counsel

Dated: January 30, 1986

Table of Contents.

Page

Table of Authorities ii

Interest of the State of New York 2

ARGUMENT:

Massachusetts and New York policy is firmly grounded on reasonable, valid federal regulations in 42 CFR §435.831 which authorize the use of a prospective period of not more than six months to compute income of the medically needy for Medicaid eligibility 4

The income standard comparability provision of 42 USC §1396a(a)(17) is irrelevant to the spend down computation 6

The "same methodology" language did not affect or change the six-month provision of 42 CFR §435.831 8

CONCLUSION. The order of the Massachusetts Supreme Judicial Court should be reversed.. 14

APPENDIX:

42 CFR §435.831 ..... 1a

42 USC §1396a(a)(10) 3a

42 USC §1396a(a)(17) 8a

Page

Table of Authorities.

CASES:

Batterton v. Francis, 435 US 416 (1977)..... 6

Cashman v. Perales, ____ F Supp ____ (WDNY, Civ. 85-0639T [1985])..... 2

Connecticut Department of Income Maintenance v. Heckler, ____ US ____, 105 S Ct 2210 (1985). 6, 13

Costanzo v. Tillinghast, 287 US 341 (1932)..... 13

DeJesus v. Perales, 770 F2d 316 (2d Cir 1985)..... 2,6

FEC v. Democrats Senatorial Campaign Committee, 454 US 27 (1981)..... 13

Hogan v. Heckler, 769 F2d 886 (1st Cir 1985)..... 8

Red Lion Broadcasting Co. v. FCC, 395 US 367 (1969)..... 13

Schweiker v. Gray Panthers, 453 US 34 (1981)..... 6

Schweiker v. Hogan, 457 US 569 (1982)..... 3, 6, 7

Udall v. Tallman, 380 US 1 (1964)..... 13

Unemployment Comm. v. Aragon, 329 US 143 (1946)..... 13

Page

UNITED STATES REGULATION:

42 CFR §435.831 ..... *Passim*

UNITED STATES STATUTES:

42 USC §602(a)(13)(A) 5

42 USC §1396a(a) 13

42 USC §1396a(a)(10) 9

42 USC §1396a(a)(10)(B) 9

42 USC §1396a(a)(10)(C)(i) 9

42 USC §1396a(a)(10)(C)(i)(III) ..... *Passim*

42 USC §1396a(a)(17) ..... *Passim*

Public Law 97-35 ..... 5, 9

Public Law 97-48, §137(a)(8) 9

Public Law 98-369 11

Social Security Act, Title XIX 6, 7

Omnibus Reconciliation Act of 1981 ..... 5, 9

Tax Equity and Fiscal Responsibility Act of 1982 ... 9

Deficit Reduction Act of 1984 11

Page

MISCELLANEOUS:

Handbook of Public Assistance Administration.... 4

H.R. Report No. 757, Part 1, 97th Congress, 2d Sess 13 (1982)..... 10, 13

H.R. Report No. 861, 98th Congress, 2d Sess, 1366-67 (1984)..... 11

House Report No. 213 of 1965, p 68, Serial Set No. 12665-2..... 7

Senate Report No. 404 of 1965, p 79, Serial Set No. 12662-3..... 7

42 Fed Reg 47976, *et seq*..... 10

No. 85-632

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1985.

CHARLES ATKINS, Commissioner of the Massachusetts Department of Welfare,

Petitioner,

v.

SANTOS RIVERA, MADELINE MCKENNA, and all other similarly situated,

Respondents.

ON A WRIT OF CERTIORARI TO THE SUPREME JUDICIAL COURT FOR THE COMMONWEALTH OF MASSACHUSETTS

Brief of the Attorney General of the State of New York *Amicus Curiae* Urging Reversal of the Order of the Massachusetts Supreme Judicial Court.

Interest of the State of New York.

New York State Department of Social Services regulations, authorized by 42 CFR §435.831, provide that, for in-hospital care, the patient's excess income for a period of six months shall be considered as available for payment in computing the amount which a person who claims to be medically needy is required to "spend down" (*i.e.*, incur) to reach New York Medicaid eligibility levels.[1] New York's spend down provision was sustained, as to the AFDC-related medically needy,[2] in *DeJesus v. Perales*, 770 F2d 316 (2d Cir, Friendly, J. [1985]).[3] The time within which plaintiff in *DeJesus* may file a petition for a writ of certiorari has been extended until February 17, 1986. It is apparent that the merits which will probably be dispositive of the application in *DeJesus* will be governed by the Court's decision here as to the Massachusetts six-month spend down provision.

New York's interest in reversal of the order here and in sustaining the judgment in *DeJesus* is substantial. The fiscal impact of an adverse judgment in *DeJesus* upon the existing New York case load (both AFDC and SSI) has been estimated by the New York State Department of

[1]For other medical care, New York uses a one-month spend down.

[2]The AFDC-related medically needy are those persons who reside with minor children and who would be eligible for Aid to Families with Dependent Children if they did not have income or resources in excess of State eligibility levels.

[3]The operation of the six-month spend down in New York is described at page 319 of the *DeJesus* opinion.

New York's spend down provision was sustained as to the SSI-related (those who are aged, blind or disabled and who would be eligible for Supplemental Security Income for the Aged, Blind or Disabled if they did not have income or resources in excess of eligibility levels) in *Cashman v. Perales*, ___F Supp___ (WDNY [1985]).

Social Services at $25 million to $30 million annually. $78 million in additional expenditures was estimated for those not presently receiving medical assistance who would become Medicaid-eligible if a one-month spend down were required. The United States, which supported New York's position in *DeJesus*, would be required to participate financially in the additional cost which a one-month spend down provision would impose upon Medicaid programs in New York and other states currently utilizing a spend down period of more than one month.

The complaint in *DeJesus* alleged that New York's six-month spend down requirement for inpatient hospital care violates the "same methodology" and "comparability" provisions of the Social Security Act, 42 USC §§ 1396a(a)(10)(C)(i)(III) and 1396a(a)(17), respectively. The opinion addressed both issues. The same attacks were made below in *Atkins*, but the decision in that case was grounded only upon the "same methodology" provision. Because a reply brief from *amici* is not permitted, we shall briefly address both aspects.[4] We believe that we can most usefully discharge our function as *amicus* by directing the Court's attention to the thorough and complete presentation of both issues as set out in *DeJesus*.

---

[4]The *Atkins* Respondents are, of course, free to argue "comparability" in support of their judgment. *Schweiker v. Hogan*, 457 US 569, 585 (1982).

ARGUMENT.

Massachusetts and New York policy is firmly grounded on reasonable, valid federal regulations in 42 CFR §435.831 which authorize the use of a prospective period of not more than six months to compute income of the medically needy for medicaid eligibility.

The use of a six-month prospective spend down period to compute the income of the medically needy to determine Medicaid eligibility has been authorized in federal law for two decades. Its promulgation in the 1966 edition of the Secretary's "Handbook of Public Assistance Administration," its subsequent codification into the Code of Federal Regulations (now 42 CFR §435.831[5]) and its application for two decades were detailed by Judge Friendly in his opinion in *DeJesus* (770 F2d at 322, n 8). Writing for the *DeJesus* court, he cautioned against "allowing a literal reading of a relatively recent amendment to set at naught the experience of administrators acquired over a score of years." *Id.* at 321.

The thrust of the argument advanced by New York, supported by the Secretary of Health and Human Services and accepted by the court in *DeJesus*, was that Congress must have known that there cannot be identity in treatment between categorically needy persons eligible for AFDC and the AFDC-related medically needy. The Court of Appeals rightly stated that persons eligible for AFDC in a given month are by definition earning no more in that month than is required for the basic necessities of life excluding medical expenses. Because they are not required to

---

[5]The regulation of the United States Secretary of Health and Human Services, 42 CFR §435.831, 42 USC §1396a(a)(10)(C)(i)(III) and 42 USC §1396a(a)(17) are reproduced *post*.

use funds required for basic necessities to pay for medical expenses, they are eligible for Medicaid (770F2d at 321).

The AFDC medically-related needy are different. Their monthly income is deemed more than sufficient to pay for the basic necessities of life. They can qualify for Medicaid, however, by "spending down" their excess income, a practice specifically authorized by 42 USC §1396a(a)(17). The Second Circuit stated that the dispute presented was whether a state in determining Medicaid eligibility for AFDC-related medically needy may calculate the spend down by taking into account a family's projected income over a six-month period, rather than over the one-month period that a state must use in determining whether a family is eligible for AFDC. 770 F2d at 322.[6]

The court recognized that New York has required a six-month spend down for coverage of inpatient hospital expenses in one form or another since the inception of its Medicaid program in 1966. After discussing the *rationale* underlying New York's policy, the court concluded that the regulations of the then Secretary of Health and Human Services (42 CFR §435.831) "plainly permit what New York has done" (770 F2d at 322) and also that those regulations were entitled to great deference. The Second

[6]The one-month provision was added to the AFDC statute in 1981 and is found in 42 USC §602(a)(13)(A). See Omnibus Budget Reconciliation Act, Public Law 97-35, §2315(a), 95 Stat 855. The Second Circuit rejected the argument that the "Secretary's long standing regulation * * * has been invalid since 1981 when Congress introduced one month budgeting in AFDC." 770 F2d at 322, n 9. Many states, it was found, used one month AFDC budgeting throughout the period that the Secretary's spend-down regulation has been in force. The *DeJesus* court found that the purpose of the 1981 amendment was to require *retrospective* one-month budgeting for AFDC to correct a high percentage of payment errors when prospective budgeting was done (*idem*).

Circuit noted that Title XIX of the Social Security Act "is shot through with references delegating the formulation of standards to the Secretary" (770 F2d at 327) and this Court's holdings in *Batterton v. Francis*, 432 US 416 (1977), and in *Schweiker v. Gray Panthers*, 453 US 34, 43 (1981), according them "legislative effect" (770 F2d at 327). Even when the Secretary has not been accorded such authority, it noted that "courts must exhibit particular deference to the Secretary's position with respect to legislation as intricate as Title XIX" (*id.*) In support of the latter proposition, the court in *DeJesus* cited *Connecticut Department of Income Maintenance v. Hecker*, ____ US ____, 105 S Ct 2210 (1985), a case having a remarkably similar factual pattern to *Atkins* and *DeJesus*, where this Court sustained a two-decade old construction of Title XIX by the Secretary, also first set out in his Handbook of Public Assistance in 1965. The issue before the *DeJesus* court then became whether there was anything in the long-existing "comparability" provision of 42 USC §1396a(a)(17) or in the "same methodology" provisions of section 1396a(a)(10)(C)(i)(III) added in 1982 which required a different result. The court first discussed "comparability." 770 F2d at 323.

The income standard comparability provision of 42 USC §1396a(a)(17) is irrelevant to the spend down computation.

The *DeJesus* court, which had decided most of the so-called comparability cases (see 770 F2d at 324, 328; *Schweiker v. Hogan*, 457 US at 588, n 28), held that it saw "little force in plaintiff's contention that New York's six-month spend down requirement violates" the statute. 770 F2d at 323. Noting that the "very purpose" of subdivision 17 "is to regulate the standards under which persons having incomes higher than allowed in the cash assistance pro-

gram may still qualify for Medicaid," it found that the statute could not be read to require that the standards must be the same as those in the cash assistance programs in all respects. Those standards, it held, are only required to be comparable, not identical, for all groups. Comparison, it noted, "invites an examination of differences as well as resemblances." It found further support for its position in this Court's opinion in *Schweiker v. Hogan*, 457 US at 587, which it read as holding that the comparability provisions of Title XIX, "including those in section 1396(a)(17) did not require that the medically needy be treated comparably to the categorically needy in all respects." 770 F2d at 324. Finally, it pointed out that subdivision 17 "invites 'flexibility' in applying income standards to the medically needy by taking into account their cost of medical care, except to the extent prescribed by the Secretary." Comparability and flexibility, both required by subdivision 17, it was stated, "do not mandate the rigidly identical treatment of categorically and medically needy Medicaid recipients for which plaintiff contends." 770 F2d at 324. *Accord Schweiker v. Hogan*, 457 at 577, n 28.

The *DeJesus* court has construed its comparability decisions and those of other courts, including this Court, correctly. The 1965 reports of both the United States Senate and the House of Representatives, written at the time of the enactment of Medicaid, dealt with what is involved in this case, *i.e.*, excess income. *See* S. Rep. No. 404, 89th Cong., 1st Sess. 79 (1965), Serial Set No. 12662-3, and H.R. Rep. No. 213, 89th Cong., 1st Sess. 68 (1965), Serial Set No. 12665-2. Only the medically needy have excess income. The categorically needy by definition do not. Excess income is determinable only *after* the budgeting process is completed. By the very nature of things, the relief sought

in *Atkins* and in *DeJesus* will not and cannot achieve an identical result as between the medically needy AFDC-related and the AFDC-categorically eligible. What plaintiff seeks in both cases is a one-month spend down, rather than a six-month spend down. Be it one month or six months, however, an AFDC-related medically needy person will be required to incur medical expenses equal to a spend down measured by "excess income." That requirement cannot be applicable to the AFDC-categorically eligible who receive Medicaid, without regard to their medical expenses, simply because they receive AFDC.

The spend down provisions of 42 USC §1396a(a)(17), set out in the same subdivision as the comparability provisions, do not contemplate identical treatment with respect to excess income for the medically needy and the AFDC categorically eligible because only the former have excess income. Those spend down provisions stand by themselves. Their application by Massachusetts and by New York should be sustained.

The "same methodology" language did not affect or change the six-month provision of 42 CFR §435.831.

The State court in *Atkins* has ignored the Secretary's construction of the Social Security Act, sustained in *DeJesus*,[7] by holding that the length of the spend down period is part of the methodology for evaluating income eligibility of the AFDC-related medically needy within the "same methodology" language of 42 USC §1396a(a)(10)

[7]This construction was sustained also as to the Massachusetts SSI-related medically needy in *Hogan v. Heckler*, 769 F2d 886 (1st Cir. 1985), *reversing* 597 F Supp 1106 (D. Mass. 1984), which had been relied upon by the *Atkins* court. The Secretary filed briefs in support of his regulation in both *DeJesus* (as *amicus curiae*) and in *Heckler* (as a party).

(C)(i)(III) (Petition, p A25). That provision, added by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Public Law No. 97-48, §137[a][8]; 96 Stat 324, 378), requires a State, in determining income under the "single standard to be employed in determining income * * * eligibility," to use the "same methodology" as would be used for determining eligibility for the "most closely categorically related" groups. Here that group is those who are eligible for AFDC.

The *DeJesus* court has correctly found that the "same methodology" language did not affect or change the six-month provision of 42 CFR §435.831, and that such language does not apply to the spend down determination, an extra step unique to Medicaid. That court reviewed the pre-TEFRA provisions of then section 1396a(a)(10)(B) which, it stated, contained a requirement that a state's Medicaid plan use comparable criteria in calculating income and resources for the categorically and medically needy. It noted, however, that the section "imposed no requirement for how such plans should determine whether a medically needy person's income and resources were insufficient to meet medical costs." 770 F2d at 324-325.

The next changes in section 1396a(a)(10), preceding TEFRA, were effected by the Omnibus Budget Reconciliation Act of 1981 (OBRA) (Public Law No. 97-35; 95 Stat 357) which required only that a state's Medicaid plan for the medically needy include "a description of * * * the criteria for determining eligibility of individuals in the [medically needy] group for * * * medical assistance" (§1396a[a][10][C][i], §2171[a][3]; 95 Stat 807).[8] The court

[8]It is hardly disputable that OBRA and TEFRA were enacted by a cost-cutting Congress. There has been absolutely no showing, and we know of none, of an intent on the part of Congress to assume the massive additional expenditures which would be incurred if the states using a six-month spend down were reduced to a one-month spend

(Footnote continued on following page.)

then discussed the HHS position on the OBRA amendments as set out in its release published at 42 Fed Reg 47976, *et seq.*, in 1981, which allowed states to use income and resource criteria for the medically needy which were different from those applicable to the categorically needy. The regulations promulgated at that time, the court stated, "had nothing to do with the treatment of exess income for the medically needy or with the calculation of spend downs." 770 F2d at 325. The opinion quoted the Federal Register release verbatim and went on to note the "[c]ongressional displeasure with the Secretary's regulations" as expressed on the floor of the House of Representatives and in H.R. Report No. 757, Part 1, 97th Congress, 2d Sess 13 (1982). That report, set out at length in the court's opinion, 770 F2d at 325-326, took note of the Secretary's construction of OBRA as evincing an intent "to give the States extensive flexibility" as to the applicable income and resource eligibility rules, and said that such conclusion was incorrect. The report stated that the OBRA conferees had not "[invited] a wholesale rewriting of current income and resource standards and methodologies," and that the Department had no authority to alter the rules that applied before September 30, 1981 with respect to medically needy income levels, medically needy resource levels and the methodology for treating medically needy income and resources. The Committee concluded "[t]he committee Bill reaffirms the financial requirements previously in effect for the medically needy (42 C.F.R. Sec. 435.800-435.845)." Included, of course, was section 435.831, the Secretary's regulation involved in these cases.

(Footnote continued.)

down period. The United States, which participates financially with the states in the cost of medical assistance for the AFDC-related and the SSI-related (approximately 50% as to New York State), would incur large and unanticipated expenditures. Such was not the intent of the Congress in dealing with the medically needy in OBRA in 1981 or TEFRA in 1982.

The *DeJesus* court accepted the Secretary's position, also advanced by New York, that the legislative history makes clear that the "same methodology" language of TEFRA was intended to invalidate provisions of the Department's 1981 regulations which permitted the income and resource standards in state Medicaid plans to deviate from those used in AFDC and SSI programs, and that in enacting that language

> "Congress * * * did not at all intend to affect HHS's regulations dealing with treatment of excess income and the calculation of spend-downs—regulations which the Secretary had not altered following OBRA and which, in her view, the last sentence of the House Report * * * expressly reaffirmed." 770 F2d at 326.[9]

The *DeJesus* court stated that the spend down is not a part of the section 1396a(a)(10)(C)(i)(III) "standard to be employed in determining income and resource eligibility"; that such standard "so far as concerns income, is whether an applicant's monthly income after deduction of various expenses (other than medical expenses) and disregards is

---

[9]Support for the Secretary's reading of the "same methodology" language was found by the court in the legislative history of the Deficit Reduction Act of 1984, Public Law No. 98-369, 98 Stat 494, at which time Congress imposed a moratorium on disapproval of state Medicaid plans that might be determined by the Secretary to be inconsistent with the "same methodology" provisions (§2372[c][1]; 98 Stat 1112). It was found that Congress in imposing the moratorium reaffirmed that its sole intent in enacting the "same methodology requirement" had been to invalidate HHS's 1981 regulations "allowing the states to impose more restrictive [income and resource] standards and methodologies than under previous law * * * for determining eligibility of the medically needy." *See* H.R. Report NO. 861, 98th Cong. 2d Sess. 1366-67 (1984). The *Atkins* court has read such legislative history incorrectly as having application to other than income and resource standards (Petition, p A26).

not more than the Medicaid income level set by the state." 770 F2d at 326. The spend down, it was stated, is not part of that standard but is "the method by which a family that does not meet the standard can nonetheless bring its excess income down to the level required for inclusion in the Medicaid program (770 F2d at 326).

The court concluded:

> "While in one sense New York's six-month spend-down requirement may be a 'methodology,' Congress can hardly have regarded it as such for purposes of [section 1396a(a)(C)(i)(III)]: since the spend-down has no counterpart in the eligibility methodologies of the cash assistance programs, it would have been tautologous for Congress to direct that states calculate spend-downs using 'the same methodology' as they use in determining eligibility for those programs. Given the history showing that Congress was aiming its shafts in TEFRA at actions of the Secretary involving quite different matters, and indeed arguably was approving the Secretary's pre-OBRA regulation permitting a spend-down of up to six months (a regulation that had gone unchallenged for over 17 years), we cannot say that the Secretary's construction is untenable, although we recognize that a different one also might not be.
>
> "This conclusion is all that is required to sustain the Secretary's position that New York's six-month spend-down requirement. * * * is authorized by HHS's longstanding regulation * * * 42 C.F.R. §435.831 (1984)" (770 F2d at 327).

While the court did not do so, it could have cited this Court's opinions in *FEC v. Democrats Senatorial Campaign Committee,* 454 US 27, 39 (1981); *Udall v. Tallman,* 380 US 1, 16 (1964), and *Unemployment Comm. v. Aragon,* 329 US 143, 153 (1946), in support of this holding. See, also, *Connecticut Department of Income Maintenance v. Heckler,* 105 S.Ct. at 2215; *Costanzo v. Tillinghaust,* 287 US 341, 345 (1932); *Red Lion Broadcasting Co. v. FCC,* 395 US 367, 381 (1969).

The "same methodology" provisions of section 1397a(a)(10)(C)(i)(III), the comparability provisions of subdivision 17 of that section, and the spend down-flexibility provisions of subdivision 17 are not only all part of the Social Security Act. They are part of the same section and the same subdivision i.e., 42 USC §1396a(a), the purpose of which is to define what a State Medicaid plan must provide. The Seeretary's construction of that subdivision, supported by the *DeJesus* court, as well as by the decision of the United States Court of Appeals for the First Circuit in *Hogan v. Heckler,* has been consistent and reasonable. The Secretary did not exceed his statutory authority in promulgating 42 CFR §435.831, nor is that regulation arbitrary or capricious. *Batterton v. Francis; Schweiker v. Gray Panthers.* It plainly and properly permits what Massachusetts and New York have done.

CONCLUSION.

The order of the Massachusetts Supreme Judicial Court should be reversed.

Dated: Albany, New York
January 21, 1986

Respectfully submitted,

ROBERT ABRAMS
Attorney General of the
State of New York

ROBERT HERMANN
Solicitor General
State of New York

PETER H. SCHIFF
Deputy Solicitor General
State of New York

ALAN W. RUBENSTEIN
Assistant Attorney General
State of New York

JOHN P. BAILLY, JR.
Deputy Counsel
New York State Department
of Social Services
of Counsel

42 CFR

§435.831 Income eligibility.

The agency must determine income eligibility of medically needy individuals in accordance with this section. The agency must use a prospective period of not more than 6 months to compute income.

(a) *Determining countable income.* The agency must deduct the following amounts from income to determine the individual's countable income.

(1) For individuals under age 21 and caretaker relatives, the agency must deduct amounts that would be deducted in determining eligibility under the State's AFDC plan.

(2) For aged, blind, or disabled individuals in States covering all SSI recipients, the agency must deduct amounts that would be deducted in determining eligibility under SSI. However, the agency must also deduct the highest amounts from income that would be deducted in determining eligibility for optional State supplements if these supplements are paid to all individuals who are receiving SSI or would be eligible for SSI except for their income.

(3) For aged, blind or disabled individuals in States using income requirements more restrictive than SSI, the agency must deduct amounts that are no more restrictive than those used under the Medicaid plan on January 1, 1972 and no more liberal than those deducted in determining eligibility under SSI or an optional State supplement. However, the amounts must be at least the same as those that would be deducted in determining eligibility, under §435.121, of the categorically needy.

(b) *Eligibility based on countable income.* If countable income determined under paragraph (a) of this section is equal to or less than the applicable income standard under §435.814, the individual or family is eligible for Medicaid.

(c) *Deduction of incurred medical expenses.* (1) If countable income exceeds the income standard, the agency must deduct from income, in the following order, incurred medical expenses that are not subject to payment by a third party:

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges, incurred by the individual or family or financially responsible relatives, including enrollment fees, copayments, or deductibles imposed under §447.51 or §447.53 of this subchapter.

(ii) Expenses incurred by the individual or family or financially responsible relatives for necessary medical and remedial services that are recognized under State law but not included in the plan.

(iii) Expenses incurred by the individual or family or by financially responsible relatives for necessary medical and remedial services that are included in the plan.

(2) The agency may set reasonable limits on the amounts of incurred medical expenses to be deducted from income under paragraphs (c) (1) (i) and (ii) of this section.

(d) *Eligibility based on incurred medical expenses.* Once deduction of incurred medical expenses reduces income to the income standard, the individual is eligible for Medicaid.

42 USC

§1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

* * *

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5) and (17) of section 1396d(a) of this title, to—

(i) all individuals—

(I) who are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A or part E of subchapter IV of this chapter (including individuals eligible under this subchapter by reason of section 602(a)(37) or 606(h) of this title, or considered by the State to be receiving such aid as authorized under section 614(g) of this title),

(II) with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or

(III) who are qualified pregnant women or children as defined in section 1396d(n) of this title;

(ii) at the option of the State, to any group or groups of individuals described in section 1396d(a) of this title (or, in the case of individuals described in section 1396d(a)(i) of this title, to any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but—

(I) who meet the income and resources' requirements of the appropriate State plan described in clause (i) or the supplemental security income program (as the case may be).

(II) who would meet the income and resources requirements of the appropriate State plan described in clause (i) if their work-related child care costs were paid from their earnings rather than by a State agency as a service expenditure.

(III) who would be eligible to receive aid under the appropriate State plan described in clause (i) if coverage under such plan was as broad as allowed under Federal law.

(IV) with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, aid or assistance under the appropriate State plan described in clause (i), supplemental security income benefits under subchapter XVI of this chapter, or a State supplementary payment;

(V) who are in a medical institution, who meet the resource requirements of the appropriate State plan described in clause (i) or the supplemental

security income program, and whose income does not exceed a separate income standard established by the State which is consistent with the limit established under section 1396b(f)(4) (C) of this title, or

(VI) who would be eligible under the State plan under this title if they were in a medical institution, with respect to whom there has been a determination that but for the provision of home or community-based services described in section 1396n(c) of this title they would require the level of care provided in a hospital, skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan, and who will receive home or community-based services pursuant to a waiver granted by the Secretary under section 1396n(c) of this title;

(B) that the medical assistance made available to any individual described in subparagraph (A)—

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A);

(C) that if medical assistance is included for any group of individuals described in section 1396d(a) of this title who are not described in subparagraph (A), then—

(i) the plan must include a description of (I) the criteria for determining eligibility of individuals in the group for such medical assistance, (II) the amount, duration, and scope of medical assistance made available to individuals in the group, and (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligiblity, which shall be the same methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be the same methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups:

(ii) the plan must make available medical assistance—

(I) to individuals under the age of 18 who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A)(i), and

(II) to pregnant women, during the course of their pregnancy, who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A);

(iii) such medical assistance must include (I) with respect to children under 18 and individuals entitled to institutional services, ambulatory services, and (II) with respect to pregnant women, prenatal care and delivery services; and

(iv) if such medical assistance includes services in institutions for mental diseases or intermediate care facility services for the mentally retarded (or both) for any such group, it also must include for all groups covered at least the care and services listed in paragraphs (1) through (5) and (17) of section 1396d(a) of this title or the care and services listed in any 7 of the paragraphs numbered (1) through (17) of such section; and

(D) for the inclusion of home health services for any individual who, under the State plan, is entitled to skilled nursing facility services;

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1396d(a) of this title to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages. (II) the making available of supplementary medical insurance benefits under part B of subchapter XVIII of this chapter to individuals eligible therefor (either pursuant to an agreement entered into under section 1395v of this title or by reason of the payment of premiums under such subchapter by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of subchapter XVIII of this chapter for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals. (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance

made available to individuals described in clause (A) to any classification of individuals approved by the Secretary with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason by this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A) and (IV) the imposition of a deductible, cost sharing, or similar charge for any item or service furnished to an individual not eligible for the exemption under section 1396d(a)(2) or (b)(2) of this title shall not require the imposition of a deductible, cost sharing, or similar charge for the same item or service furnished to an individual who is eligible for such exemption:

* * *

42 USC §1396a(a)(10)(A)(i) is quoted as amended by the Deficit Reduction Act of 1984, Public Law 98-369, §§ 2361(a) and 2373(b)(2) (98 Stat 1104 and 1111) and by Public Law 98-378, §20(c) (98 Stat 1322).

* * *

(17) include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under sub-

chapter XVI of this chapter, based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determinined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law;